Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

HEALTHTRUST, LLC
P O BOX 890008
HOUSTON TX 77289

Carrier's Austin Representative Box
Box Number 19

MFDR Date Received
January 26, 2012

Respondent Name
INSURANCE CO OF THE STATE OF PA

MFDR Tracking Number
M4-12-1796-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "PREAUTHORIZED TREATMENT BEING DENIED DUE TO EXTENT ISSUES EVEN AFTER BRC RULED THAT DIAGNOSIS WAS COMPENSABLE AND ALL PARTIES SIGNED REVIEW AGREEMENT"

Amount in Dispute: $28,080.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Requestor billed $28,080.00 for chronic pain management arguing that the carrier had preauthorized the treatment and that the carrier had agreed that the injury extended to contusion of the chest wall. The billing was denied initially as the treatment was not related to the compensable injury. The carrier position remains the same."

Response Submitted by: CHARTIS, 4100 Alpha Road, Suite 700, Dallas, TX 75244

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 27, 2011	97799-CP x 8 hours	$1,560.00	$800.00
May 5, 2011	97799-CP x 8 hours	$1,560.00	$800.00
May 10, 2011	97799-CP x 8 hours	$1,560.00	$800.00
June 8, 2011	97799-CP x 8 hours	$1,560.00	$800.00
June 9, 2011	97799-CP x 8 hours	$1,560.00	$800.00
June 13, 2011	97799-CP x 8 hours	$1,560.00	$800.00
June 14, 2011	97799-CP x 8 hours	$1,560.00	$800.00
June 15, 2011	97799-CP x 8 hours	$1,560.00	$800.00
June 30, 2011	97799-CP x 8 hours	$1,560.00	$800.00
July 12, 2011	97799-CP x 8 hours	$1,560.00	$800.00
July 19, 2011	97799-CP x 8 hours	$1,560.00	$800.00
July 20, 2011	97799-CP x 8 hours	$1,560.00	$800.00
July 21, 2011	97799-CP x 8 hours	$1,560.00	$800.00
July 25, 2011	97799-CP x 8 hours	$1,560.00	$800.00
July 26, 2011	97799-CP x 8 hours	$1,560.00	$800.00
July 27, 2011	97799-CP x 8 hours	$1,560.00	$800.00
July 28, 2011	97799-CP x 8 hours	$1,560.00	$800.00

August 2, 2011	97799-CP x 8 hours	$1,560.00	$800.00
TOTAL		$28,080.00	$14,400.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Tex. Administrative Code §134.600 sets out guidelines for preauthorization, concurrent review, and voluntary certification of health care..
3. 28 Texas Administrative Code §134.204 sets out medical fee guidelines for workers' compensation specific services provided on or after March 1, 2008.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated June 7, 2011
   - 1 – (96) – Non-covered charge (s).
   - 1 – The service (s) is for a condition (s) which is not related to the covered work related injury. (X347)

   Explanation of benefits dated June 21, 2011
   - 1 – (96) – Non-covered charge (s).
   - 1 – The service (s) is for a condition (s) which is not related to the covered work related injury. (X347)

   Explanation of benefits dated June 28, 2011
   - 1 – (96) – Non-covered charge (s).
   - 1 – The service (s) is for a condition (s) which is not related to the covered work related injury. (X347)

   Explanation of benefits dated July 29, 2011
   - 1 – (96) – Non-covered charge (s).
   - 1 – The service (s) is for a condition (s) which is not related to the covered work related injury. (X347)

   Explanation of benefits dated August 9, 2011
   - 1 – (96) – Non-covered charge (s).
   - 1 – The service (s) is for a condition (s) which is not related to the covered work related injury. (X347)

   Explanation of benefits dated August 24, 2011
   - 1 – (96) – Non-covered charge (s).
   - 1 – The service (s) is for a condition (s) which is not related to the covered work related injury. (X347)

Issues

1. Has the extent of injury issue been resolved?
2. Did the requestor obtain preauthorization approval prior to providing the health care in dispute in accordance with 28 Texas Administrative Code §134.600?
3. Is the requestor the requestor entitled to reimbursement?

Findings

1. A Benefit Review Conference was held on November 10, 2011 to mediate resolution of the disputed issue however, the parties were unable to reach an agreement. A Contested Case Hearing was held on January 5, 2012 that found that the compensable injury of November 10, 2011 does not extend to or include protruding discs in the lumbar spine at levels L4-5, L5-S1 and the cervical spine at levels C5-6, C6-7, and an annular tear in the lumbar spine at levels L5-S1. Per the DWC-24 dated January 19, 2012, the parties agreed that the compensable injury extended to include a chest wall contusion. The provider billed the disputed treatment for the diagnosis, 922.1 (contusion of chest wall). The Division has determined that the extent of injury issue has been resolved, and the disputed services will be reviewed per the applicable Division rules and fee guidelines.

2. 28 Texas Administrative Code §134.600(p)(10) requires preauthorization of "chronic pain management/interdisciplinary pain rehabilitation." Review of the submitted preauthorization letter dated March 14, 2011 supports the Chronic Pain Management Program x 80 hours (10 sessions) was approved under authorization number 063525301 with a start date of March 9, 2011 and an end date of May 15, 2011; preauthorization letter dated May 25, 2011 supports approval for an additional 48 hours (6 sessions, 8 hours per session) under authorization number 065008501 with a start date of May 25, 2011 and an end date of August 23, 2011; and preauthorization letter dated June 22, 2011 supports approval for 80 hours under authorization number 065516201 with a start date of June 17, 2011 and an end date of August 1, 2011 which includes the disputed service. The requestor has supported their position that the disputed chronic pain management program was preauthorized per 28 Texas Administrative Code, Section §134.600; therefore, the requestor is entitled to reimbursement as follows per 28 Texas Administrative Code, Section §134.204.
3. Per 28 Texas Administrative Code §134.204(h)(5)(B), states "Reimbursement shall be $125.00 per hour. Units of less than one hour shall be prorated in 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to eight minutes and less than 23 minutes." Review of the submitted documentation finds that based on the factual determination that the provider billed the disputed services without the –CA modifier, reimbursement will be 80% of the CARF maximum allowable reimbursement (MAR).

DOS April 27, 2011: $100.00 x 8 hours = $800.00
DOS May 5, 2011: $100.00 x 8 hours = $800.00
DOS May 10, 2011: $100.00 x 8 hours = $800.00
DOS June 8, 2011: $100.00 x 8 hours = $800.00
DOS June 9, 2011: $100.00 x 8 hours = $800.00
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DOS July 26, 2011: $100.00 x 8 hours = $800.00
DOS July 27, 2011: $100.00 x 8 hours = $800.00
DOS July 28, 2011: $100.00 x 8 hours = $800.00
DOS August 2, 2011: $100.00 x 8 hours = $800.00

TOTAL DUE: $14,400.00

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $ 14,400.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $14,400.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	June 29, 2012 Date
Signature	Medical Fee Dispute Resolution Manager	June 29, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.